FOR OHF USE

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040394

Facility Name: GLENWOOD CARE CENTER

Address: 222 N. HAMMES (Number) JOLIET (City) 60435 (Zip Code)

County: WILL

Telephone Number: (847) 329-1555 **Fax #** (847) 329-9555

IDPA ID Number: 36-3873066

Date of Initial License for Current Owners: 04/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) SHERWIN I. RAY

(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA, PARTNER

(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	203	Skilled (SNF)	203	74,298	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	203	TOTALS	203	74,298	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			6,001	6,001	8
9	SNF/PED					9
10	ICF	39,177	3,518		42,695	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,177	3,518	6,001	48,696	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.54%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 29 and days of care provided 5,315

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	182,165	21,670	16,060	219,895		219,895	(4,200)	215,695			1
2	Food Purchase		180,661		180,661	(18,282)	162,379	(508)	161,871			2
3	Housekeeping	154,938	28,862		183,800		183,800		183,800			3
4	Laundry	52,363	15,829		68,192		68,192		68,192			4
5	Heat and Other Utilities			164,736	164,736		164,736	674	165,410			5
6	Maintenance	115,519	22,253	43,356	181,128		181,128	10,844	191,972			6
7	Other (specify):*			11,163	11,163		11,163	354	11,517			7
8	**TOTAL General Services**	504,985	269,275	235,315	1,009,575	(18,282)	991,293	7,164	998,457			8
	B. Health Care and Programs											
9	Medical Director			7,700	7,700		7,700		7,700			9
10	Nursing and Medical Records	1,652,797	79,508	900	1,733,205		1,733,205	25,941	1,759,146			10
10a	Therapy	37,919	8,642	97,683	144,244		144,244	(83,345)	60,899			10a
11	Activities	65,417	3,706		69,123		69,123		69,123			11
12	Social Services	180,686			180,686		180,686		180,686			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,936,819	91,856	106,283	2,134,958		2,134,958	(57,404)	2,077,554			16
	C. General Administration											
17	Administrative	97,535			97,535		97,535	69,545	167,080			17
18	Directors Fees											18
19	Professional Services			269,107	269,107		269,107	(196,557)	72,550			19
20	Dues, Fees, Subscriptions & Promotions			26,459	26,459		26,459	(9,195)	17,264			20
21	Clerical & General Office Expenses	51,305	12,314	249,564	313,183		313,183	(130,307)	182,876			21
22	Employee Benefits & Payroll Taxes			431,713	431,713	18,282	449,995		449,995			22
23	Inservice Training & Education			695	695		695	1,248	1,943			23
24	Travel and Seminar			4,025	4,025		4,025	411	4,436			24
25	Other Admin. Staff Transportation			913	913		913	4,144	5,057			25
26	Insurance-Prop.Liab.Malpractice			137,039	137,039		137,039	2,608	139,647			26
27	Other (specify):*							45,973	45,973			27
28	**TOTAL General Administration**	148,840	12,314	1,119,515	1,280,669	18,282	1,298,951	(212,130)	1,086,821			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,590,644	373,445	1,461,113	4,425,202		4,425,202	(262,370)	4,162,832			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: GLENWOOD CARE CENTER **#0040394** **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	10,166	
	REPAIRS & MAINTENANCE		5,894	
			0	16,060
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		29,975	
	ELECTRICITY		89,084	
	WATER		44,318	
	CABLE TV - LOBBY		1,359	
			0	164,736
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,965	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		24,863	
	ELEVATOR MAINTENANCE & REPAIR		6,578	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,563	
	FIRE SERVICE		4,387	
			0	
			0	
			0	43,356
7	**OTHER**			
	SCAVENGER		11,163	
	SECURITY SERVICE		0	11,163
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	7,700	7,700

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	0	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	600	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL SERVICE		300	
			0	900
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		8,006	
	SPEECH THERAPY SERVICES		635	
	OCCUPATIONAL THERAPY SERVICES		13,784	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	7,200	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	7,200	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	THERAPY CONTRACT SERVICES	XVIII B 43-2	60,858	97,683
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number GLENWOOD CARE CENTER **#0040394** **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	26,935	
	ADMINISTRATIVE CONSULTANTS	XIX C	186,000	
	PROFESSIONAL FEES	XIX C	56,172	
			0	269,107
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	11,993	
	EMPLOYEE WANT ADS	XIX F	10,266	
	CONTRIBUTIONS	VI 20 XIX F	50	
	DUES & SUBSCRIPTIONS	XIX F	1,168	
	LICENSES & PERMITS	XIX F	2,785	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	47	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	150	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	26,459
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,290	
	EQUIPMENT REPAIR & MAINTENANCE		5,116	
	OUTSIDE CLERICAL SERVICES		123,368	
	PENALTIES / OVERDRAFT CHARGES	VI 18	99,969	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		18,994	
	MESSENGER SERVICE		827	
			0	249,564

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	196,033	
	UNEMPLOYMENT COMPENSATION	XIX D	61,665	
	WORKERS COMPENSATION INSURANCI	XIX D	44,921	
	HOSPITALIZATION INSURANCE	XIX D	100,980	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,500	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	26,614	
	CHICAGO HEAD TAX	XIX D	0	431,713
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		695	695
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	4,025	
			0	
			0	4,025
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		913	913
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		137,039	137,039
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 1,461,113

GLENWOOD CARE CENTER
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	180,661
LESS SALES TAX	(508)
NET FOOD	180,153
TOTAL PATIENT CENSUS	48,696
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	146088
ADD # EMPLOYEE MEALS/DAY	45
TIME # DAYS	366
TOTAL EMPLOYEE MEALS	16470

PATIENT MEALS	146088
ADD EMPLOYEE MEALS	16470
TOTAL MEALS/YEAR	162558
NET FOOD	180153
DIVIDE TOTAL MEALS/YEAR	162558
COST PER MEAL	1.11
TIME EMPLOYEE MEALS	16470
EMPLOYEE MEAL RECLASSIFICATION	18282

Facility Name & ID Number GLENWOOD CARE CENTER #0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			37,074	37,074		37,074	8,361	45,435			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			142,009	142,009		142,009	28,707	170,716			32
33	Real Estate Taxes			87,691	87,691		87,691		87,691			33
34	Rent-Facility & Grounds			647,183	647,183		647,183	6,138	653,321			34
35	Rent-Equipment & Vehicles			43,038	43,038		43,038	(9,908)	33,130			35
36	Other (specify):*											36
37	**TOTAL Ownership**			956,995	956,995		956,995	33,298	990,293			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		164,812	167,988	332,800		332,800	(141,125)	191,675			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,448	111,448		111,448		111,448			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		164,812	279,436	444,248		444,248	(141,125)	303,123			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,590,644	538,257	2,697,544	5,826,445		5,826,445	(370,197)	5,456,248			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,645)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(508)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(150)	20		17
18	Fines and Penalties	(99,969)	21		18
19	Entertainment		20		19
20	Contributions	(50)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(11,993)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(47)	20		28
29	Other-Attach Schedule SEE PAGE 5 A	(11,748)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (126,110)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(244,087)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (244,087)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (370,197)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

GLENWOOD CARE CENTER

ID# 0040394

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 1057	6	1
2	DIRECTOR OF MARKETING	(12,805)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(11,748)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	(4,200)	0	0	0	0	0	0	0	0	0	(4,200)	1
2	Food Purchase	(508)	0	0	0	0	0	0	0	0	0	0	(508)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	674	0	0	0	0	0	0	0	0	0	674	5
6	Maintenance	1,057	9,787	0	0	0	0	0	0	0	0	0	10,844	6
7	Other (specify):*	0	0	354	0	0	0	0	0	0	0	0	354	7
8	**TOTAL General Services**	549	6,261	354	0	0	0	0	0	0	0	0	7,164	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	25,941	0	0	0	0	0	0	0	0	0	25,941	10
10a	Therapy	0	3,427	(86,772)	0	0	0	0	0	0	0	0	(83,345)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	29,368	(86,772)	0	0	0	0	0	0	0	0	(57,404)	16
	C. General Administration													
17	Administrative	0	69,545	0	0	0	0	0	0	0	0	0	69,545	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(196,557)	0	0	0	0	0	0	0	0	0	(196,557)	19
20	Fees, Subscriptions & Promotions	(12,240)	0	3,045	0	0	0	0	0	0	0	0	(9,195)	20
21	Clerical & General Office Expenses	(112,774)	(121,800)	104,267	0	0	0	0	0	0	0	0	(130,307)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	1,248	0	0	0	0	0	0	0	0	1,248	23
24	Travel and Seminar	0	0	411	0	0	0	0	0	0	0	0	411	24
25	Other Admin. Staff Transportation	0	0	4,144	0	0	0	0	0	0	0	0	4,144	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,608	0	0	0	0	0	0	0	0	2,608	26
27	Other (specify):*	0	0	45,973	0	0	0	0	0	0	0	0	45,973	27
28	**TOTAL General Administration**	(125,014)	(248,812)	161,696	0	0	0	0	0	0	0	0	(212,130)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(124,465)	(213,183)	75,278	0	0	0	0	0	0	0	0	(262,370)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(1,645)	0	10,006	0	0	0	0	0	0	0	0	8,361	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	28,707	0	0	0	0	0	0	0	0	28,707	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	6,138	0	0	0	0	0	0	0	0	6,138	34
35	Rent-Equipment & Vehicles	0	0	(9,908)	0	0	0	0	0	0	0	0	(9,908)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,645)	0	34,943	0	0	0	0	0	0	0	0	33,298	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	(141,125)	0	0	0	0	0	0	0	0	(141,125)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	(141,125)	0	0	0	0	0	0	0	0	(141,125)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(126,110)	(213,183)	(30,904)	0	0	0	0	0	0	0	0	(370,197)	45

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT.	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHAB.	SKOKIE	THERAPY
SEE ATTACHED SCHEDULE						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	DIETARY CONSULT. FEES	$ 4,200	CAREPLUS MANAGEMENT, INC		$	$ (4,200)	1
2	V	19	DATA PROCESS FEES	14,400				(14,400)	2
3	V	21	CLERICAL FEES	121,800				(121,800)	3
4	V	19	ADMIN. CONSULT FEES	186,000				(186,000)	4
5	V								5
6	V	6	DIETARY SALARIES				2,914	2,914	6
7	V	5	UTILITIES				674	674	7
8	V	6	MAINT & REPAIRS				24	24	8
9	V	6	MAINTENANCE SALARIES				6,849	6,849	9
10	V	10	NURSING SALARIES				25,941	25,941	10
11	V	10A	THERAPY SALARIES				3,427	3,427	11
12	V	17	ADMIN SALARIES				69,545	69,545	12
13	V	19	PROFESSIONAL FEES				3,843	3,843	13
14	Total			$ 326,400			$ 113,217	$ * (213,183)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	THERAPY SERVICES	$ 96,939	CAREPLUS REHABILITATIVE SERVICES		$ 10,167	$ (86,772)	15
16	V	39	ANCILLARY THERAPY	168,730			27,605	(141,125)	16
17	V	35	EQUIPMENT RENT	16,567				(16,567)	17
18	V								18
19	V								19
20	V	20	ADVERTISING		CAREPLUS MGMT, INC.		3,045	3,045	20
21	V	21	TOTAL OFFICE				33,728	33,728	21
22	V	21	CLERICAL SALARIES				70,539	70,539	22
23	V	23	SEMINARS				1,248	1,248	23
24	V	24	TRAVEL				411	411	24
25	V	25	TRANSPORTATION				4,144	4,144	25
26	V	26	INSURANCE				2,608	2,608	26
27	V	27	EMPLOYEE BENEFITS				45,973	45,973	27
28	V	30	DEPRECIATION (SL)				10,006	10,006	28
29	V	32	INTEREST				28,707	28,707	29
30	V	34	OFFICE RENT				6,138	6,138	30
31	V	35	EQUIPMENT RENT				6,659	6,659	31
32	V	7	SECURITY				354	354	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 282,236			$ 251,332	$ * (30,904)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	SHERWIN RAY	PRESIDENT	ADMIN.FINANC	25.32	SEE ATACHED	5.2		SALARY	15,928	17-7	2
3	JAKOB BAKST	DIR OPERATIONS	ADMIN,CONSUL	24.88	SCHEDULE	5.2		SALARY	15,928	17-7	3
4	JOE ZIMMERMAN	CFO	CLERICAL	0.99		5.2		SALARY	11,408	21-7	4
5	JANICE L. CLAFFORD	CONTROLLER	CLERICAL	0.55		5.2		SALARY	5,462	21-7	5
6	ROMY MACASAET	RN CONSULTANT	NURSING	0.49		5.2		SALARY	7,210	10-7	6
7	JAMME O'BRIEN	REGIONAL DIR	ADMINISTRAT	0.49		5.2		SALARY	11,400	17-7	7
8	JOE ANN BREW	REGIONAL DIR	ADMINISTRAT	0.49		5.2		SALARY	6,365	17-7	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 73,701		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT
Street Address: 8320 SKOKIE BLVD.
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847) 329-1555
Fax Number: (847) 329-9555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	DIETARY SALARIES	CENSUS DAYS	451,049	9	$ 26,990	$	48,696	$ 2,914	1
2	5	UTILITIES	CENSUS DAYS	565,586	13	7,834		48,696	674	2
3	6	MAINT & REPAIRS	CENSUS DAYS	565,586	13	275		48,696	24	3
4	6	MAINTENANCE SALARIES	CENSUS DAYS	565,586	13	79,548		48,696	6,849	4
5	10	NURSING SALARIES	CENSUS DAYS	565,586	13	301,295		48,696	25,941	5
6	10A	THERAPY SALARIES	CENSUS DAYS	565,586	13	39,798		48,696	3,427	6
7	17	ADMIN SALARIES	CENSUS DAYS	565,586	13	807,745		48,696	69,545	7
8	19	PROFESSIONAL FEES	CENSUS DAYS	565,586	13	44,637		48,696	3,843	8
9	20	ADVERTISING	CENSUS DAYS	565,586	13	35,362		48,696	3,045	9
10	21	TOTAL OFFICE	CENSUS DAYS	565,586	13	391,736		48,696	33,728	10
11	21	CLERICAL SALARIES	CENSUS DAYS	565,586	13	819,289		48,696	70,539	11
12	23	SEMINARS	CENSUS DAYS	565,586	13	14,490		48,696	1,248	12
13	24	TRAVEL	CENSUS DAYS	565,586	13	4,769		48,696	411	13
14	25	TRANSPORTATION	CENSUS DAYS	565,586	13	48,136		48,696	4,144	14
15	26	INSURANCE	CENSUS DAYS	565,586	13	30,286		48,696	2,608	15
16	27	EMPLOYEE BENEFITS	CENSUS DAYS	565,586	13	533,964		48,696	45,973	16
17	30	DEPRECIATION (SL)	CENSUS DAYS	565,586	13	116,219		48,696	10,006	17
18	32	INTEREST	CENSUS DAYS	565,586	13	333,416		48,696	28,707	18
19	34	OFFICE RENT	CENSUS DAYS	565,586	13	71,288		48,696	6,138	19
20	35	EQUIPMENT RENT	CENSUS DAYS	565,586	13	77,344		48,696	6,659	20
21	7	SECURITY	CENSUS DAYS	565,586	13	4,112		48,696	354	21
22										22
23										23
24										24
25	TOTALS					$ 3,788,533	$		$ 326,777	25

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	CIB BANK		X	CAPITAL IMPROVEMENTS	$2,532.89	01/04	$ 336,000	$ 84,607	01/09	PRIME+	$ 5,855	1
2	LOAN COSTS		X	LOAN COSTS	W/O OVER 5 YEARS		1,125		W/O BAL		488	2
3												3
4												4
5												5
	Working Capital											
6	CAREPLUS MGMT INC	X		WORKING CAPITAL	DEMAND	04/95	1,300,000	1,742,519		PRIME+	135,418	6
7	A.I. CREDIT INC.		X	INSURANCE FINANCED							248	7
8	CAREPLUS MGMT ALLOCATION										28,707	8
9	TOTAL Facility Related				$2,532.89		$ 1,637,125	$ 1,827,126			$ 170,716	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,637,125	$ 1,827,126			$ 170,716	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 89,213	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 88,012	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,201)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 88,892	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 87,691	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	75,565	8
	2000	79,467	9
	2001	82,562	10
	2002	88,330	11
	2003	88,012	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GLENWOOD CARE CENTER COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0040394

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-07-07-304-025-0000	NURSING HOME	$ 88,012.08	$ 88,012.08
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 88,012.08	$ 88,012.08

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 80,000 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	75,625		$	1
2					2
3	TOTALS	75,625		$	3

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1993	1,080	34	31.5	34		398	9
10	LEASEHOLD IMPROVEMENTS			1993	26,757	686	39	686		7,851	10
11	LEASEHOLD IMPROVEMENTS			1994	4,980	128	39	128		1,381	11
12	OUTLETS			1995	1,429	37	39	37		344	12
13	PAVING			1995	19,500	1,300	15	1,300		12,356	13
14	ROOF REPAIR			1996	2,505	64	39	64		568	14
15	ELEVATOR REPAIR			1996	7,000	180	39	180		1,576	15
16	WATER CONDITIONING SYSTEM			1996	3,486	89	39	89		775	16
17	ROOFTOP A/C UNIT			1996	5,300	136	39	136		1,094	17
18	LANDSCAPING			1996	3,554	237	15	237		2,014	18
19	EXTERIOR PLASTER/PAINT			1997	8,500	218	39	218		1,699	19
20	PLUMBING			1997	1,091	28	39	28		214	20
21	LAMINATED COUNTER TOPS			1997	5,900	151	39	151		1,087	21
22	WALK-IN COOLER			1998	9,893	254	39	254		1,767	22
23	OUTDOOR STORAGE UNIT			1998	1,200	31	39	31		213	23
24	DRAIN LINE REPAIRS			1998	6,575	168	39	168		1,140	24
25	ROOFTOP HEAT / AC UNIT			1998	5,200	133	39	133		826	25
26	LANDSCAPING			1998	5,883	392	15	392		2,548	26
27	ROOF & HEATING REPAIRS / FIRE SAFETY UPGRADE			1999	17,798	456	39	456		2,362	27
28	NEW SUSPENDED CELLING			2000	64,670	2,352	27.5	2,352		11,373	28
29	CARPET-ENTRANCE & LOBBY			2000	2,750	276	20	138	(138)	690	29
30	NEW DIALYSIS ROOM			2001	8,750	318	27.5	318		1,232	30
31	INSTALLATION WATER SYSTEM			2001	1,905	69	27.5	69		268	31
32	FIRE ALARM SYSTEM-NEW HORNS,SMOKE DETECTORS			2001	7,194	262	27.5	262		862	32
33	DRYWALL			2001	5,425	197	27.5	197		649	33
34	PASSENGER ELEVATOR-PUMPING UNIT			2001	9,700	353	27.5	353		1,074	34
35	REPLACE WATER HEATER			2001	4,411	160	27.5	160		487	35
36	ROOF REPAIR			2002	3,100	113	27.5	113		315	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	NURSES STATION WITH SURFACE TRANSACTION TOP	2002	$ 17,820	$ 648	27.5	$ 648	$	$ 1,431	37
38	VESTIBULE, LOBBY,DINING ROOMS - WALLCOVERING	2002	7,200	262	27.5	262		716	38
39	REPLACE THE ELEVATOR PUMPING UNIT	2002	4,700	171	27.5	171		477	39
40	NURSES' STATIONS-WALLCOVERING, ELECTRIC. WORK	2002	5,440	198	27.5	198		469	40
41	REPAIR PATCH AT FRONT OF BUILDING	2002	1,720	115	15	115		345	41
42	BUILD NEW WALL BETWEEN LOBBY & NURSES STATION	2002	6,930	252	27.5	252		578	42
43	LOBBY, VESTIBULE, CORRIDOR-FLOORING	2002	34,654	1,260	27.5	1,260		2,783	43
44	FACILITY DOOR	2003	3,072	112	27.5	112		172	44
45	GREASE TRAPS	2003	3,900	141	27.5	141		218	45
46	DELAYS FOR PATIO DOORS	2003	3,049	111	27.5	111		171	46
47	FENCE	2003	3,950	263	15	263		395	47
48	ROOF DRAIN	2003	1,900	69	27.5	69		78	48
49	FIRE ALARM SYSTEM	2003	6,198	225	27.5	225		253	49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57	CAREPLUS MGMT INC.: LEASEHOLD IMPROVEMENTS			101		101			57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 346,069	$ 12,750		$ 12,612	$ (138)	$ 65,249	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 225,274	$ 16,098	$ 19,420	$ 3,322	3-15	$ 121,340	71
72	Current Year Purchases	13,695	6,801	848	(5,953)	8-10	848	72
73	Fully Depreciated Assets	10,178					10,178	73
74	RELATED PARTY ALLOC: SL DEPR		9,905	9,905				74
75	TOTALS	$ 249,147	$ 32,804	$ 30,173	$ (2,631)		$ 132,366	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	1998 CHEVROLET VAN	2001	$ 13,250	$ 1,526	$ 2,650	$ 1,124	5	$ 10,600	76
77										77
78										78
79										79
80	TOTALS			$ 13,250	$ 1,526	$ 2,650	$ 1,124		$ 10,600	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 608,466	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 47,080	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 45,435	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,645)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 208,215	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: METROPOLITAN NURSING CENTER OF JOLIET

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1970	203	04/01/93	$ 647,183	30		3
4	Additions							4
5								5
6								6
7	TOTAL		203		$ 647,183 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 43,038 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19			N/A		19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number GLENWOOD CARE CENTER

STATE OF ILLINOIS
0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 116,530	$		$ 116,530	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,571			1,571	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			49,887			49,887	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				157,528		157,528	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES Other (specify): RENTALS, LAB	39-2 39-2					5,122 2,162		5,122 2,162	13
14	TOTAL			$		$ 167,988	$ 164,812		$ 332,800	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (101,787)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,277,609		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,281		6
7	Other Prepaid Expenses	45,887		7
8	Accounts Receivable (owners or related parties)	430,516		8
9	Other(specify): Real Estate Tax Escrow	66,979		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,732,485	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	346,069		15
16	Equipment, at Historical Cost	262,397		16
17	Accumulated Depreciation (book methods)	(296,221)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): RENT SECURITY DEPOSIT	487,200		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 799,445	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,531,930	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 817,078	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,446		28
29	Short-Term Notes Payable	2,568,626		29
30	Accrued Salaries Payable	93,841		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,674		31
32	Accrued Real Estate Taxes(Sch.IX-B)	88,892		32
33	Accrued Interest Payable	8,244		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,633,801	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,633,801	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (101,871)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,531,930	$	48

*(See instructions.)

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (14,505)	1
2	Restatements (describe):	(429,463)	2
3	POST CLOSING ADJ		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (443,968)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	342,097	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 342,097	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (101,871)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,167,738	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,167,738	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	689	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 689	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	115	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 115	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,168,542	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,009,575	31
32	Health Care	2,134,958	32
33	General Administration	1,280,669	33
	B. Capital Expense		
34	Ownership	956,995	34
	C. Ancillary Expense		
35	Special Cost Centers	332,800	35
36	Provider Participation Fee	111,448	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,826,445	40
41	**Income before Income Taxes (line 30 minus line 40)****	342,097	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 342,097	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,854	2,057	$ 64,735	$ 31.47	1
2	Assistant Director of Nursing	915	999	31,733	31.76	2
3	Registered Nurses	19,382	20,038	548,175	27.36	3
4	Licensed Practical Nurses	14,306	14,853	325,113	21.89	4
5	Nurse Aides & Orderlies	67,742	70,608	664,442	9.41	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,921	3,175	37,919	11.94	8
9	Activity Director	1,234	1,288	14,117	10.96	9
10	Activity Assistants	7,285	7,549	51,300	6.80	10
11	Social Service Workers	7,456	8,135	180,686	22.21	11
12	Dietician					12
13	Food Service Supervisor	1,141	1,176	19,508	16.59	13
14	Head Cook	6,001	6,478	57,818	8.93	14
15	Cook Helpers/Assistants	13,394	13,820	104,839	7.59	15
16	Dishwashers					16
17	Maintenance Workers	12,239	12,642	115,519	9.14	17
18	Housekeepers	16,678	17,892	154,938	8.66	18
19	Laundry	5,987	6,515	52,363	8.04	19
20	Administrator	2,051	2,480	68,418	27.59	20
21	Assistant Administrator	870	943	29,117	30.88	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,575	3,729	38,500	10.32	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,997	2,090	18,599	8.90	31
32	Other Health Care(specify)					32
33	Other(specify) MAEKETING	592	592	12,805	21.63	33
34	TOTAL (lines 1 - 33)	188,620	197,059	$ 2,590,644 *	$ 13.15	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 10,166	1-3	35
36	Medical Director	O	7,700	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	600	10-3	39
40	Physical Therapy Consultant	L	7,200	10a-3	40
41	Occupational Therapy Consultant	Y	7,200	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 32,866		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
TAMMY STONEBERGER	ADMIN	0	$ 68,418
AMY WALKO	ASST ADMIN	0	29,117
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 97,535

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		269,107
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 269,107

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 44,921
Unemployment Compensation Insurance		61,665
FICA Taxes		196,033
Employee Health Insurance		100,980
Employee Meals		18,282
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		1,500
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		26,614
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 449,995

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	10,266
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	12,040
TRUST/FRANCHISE/CONTRIB/ETC	200
LICENSES & PERMITS	1,790
DUES & SUBSCRIPTIONS	1,168
MGMT CO ALLOCATION	3,045
TRUST/FRANCHISE/CONTRIB/ETC	(200)
Less: Public Relations Expense	(0)
Non-allowable advertising	(11,993)
Yellow page advertising	(47)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,264

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	4,025
MGMT CO ALLOCATION	411
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,436

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING/DECORATIN	2002	$ 3,172	3 YRS	$	$ 529	$ 1,057	$ 1,057	$ 529	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 3,172		$	$ 529	$ 1,057	$ 1,057	$ 529	$	$	$	$

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **NO**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **633** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **111,448**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **18,282** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees